Washington State Department of Social & Health Services
HRSA Health & Recovery Services Administration

# General Information for Authorization

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|---|---|---|---|
| Org | 1. 508 | Service Type | 2. T |
| **Client Information** | | | |
| Name | 3. CLIENT NAME | Client ID | 4. 123456789WA |
| Living Arrangements | 5. | Reference Auth # | 6. |
| **Provider Information** | | | |
| Requesting NPI # | 7. 1123456789 | Requesting Fax # | 8. XXXXXXXXXX |
| Servicing NPI # | 9. 1123456789 | Name | 10. SERVICING PROVIDER NAME |
| Referring NPI # | 11. 1123456789 | Referring Fax # | 12. XXXXXXXXXX |
| Service Start Date: | 13. | | 14. N/A |
| **Service Request Information** | | | |
| Description of service being requested: 15. Additional Speech therapy | | 16. N/A | 17. N/A |
| 18. Serial / NEA# N/A | | 19. N/A | |

| 20. Code Qualifier | 21. National Code | 22. Mod | 23. # Units/Days Requested | 24. $ Amount Requested | 25. Part # (DME Only) | 26. Tooth or Quad # |
|---|---|---|---|---|---|---|
| C | | | 96 | N/A | N/A | N/A |
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| **Medical Information** | | | |
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| Diagnosis Code | 27. ICD-9 | Diagnosis name | 28. |
| Place of service | 29. | | |
| 30. Comments: | | | |

www.WaProviderOne.org

**Instructions to fill out the General Information for Authorization form, DSHS 13-835**

| FIELD | NAME | ACTION |
|---|---|---|
| | | ALL FIELDS MUST BE TYPED. |
| 1 | Org required | Enter the Number that Matches the Program/Unit for the Request<br>500 - Division of Alcohol and Substance Abuse (DASA)<br>501 - Dental<br>502 - Durable Medical Equipment (DME)<br>509 - Economic Services Administration (ESA) (DSHS)<br>504 - Home Health<br>505 - Hospice<br>506 - Inpatient Hospital<br>507 - Juvenile Rehabilitation Administration (JRA) (DSHS)<br>508 - Medical<br>509 - Medical Nutrition<br>510 - Mental Health<br>511 - Outpt Proc/Diag<br>513 - Physical Medicine & Rehabilitation (PM & R)<br>514 - Aging and Disability Services Administration (ADSA)<br>515 - Transportation<br>516 - Miscellaneous |
| 2 | Service Type required | Enter the letter(s) in all CAPS that represent the service type you are requesting.<br>AA Ambulatory Aids<br>BB Bath Bench<br>BEM Bath Equipment (misc)<br>BGM Blood Glucose Monitors<br>BGS Bone Growth Stimulator<br>BP Breast Pumps<br>BS Bariatric surgery<br>BSS2 Bariatric surgery stage 2<br>C Commode<br>CI Cochlear Implants<br>CIERP Cochlear Implant Ext Repl Prts<br>CSC Commode/Shower Chair<br>CWN Crowns<br>DASA DASA<br>DEN Dentures<br>EN Enteral Nutrition<br>ESA ESA<br>FSFS Floor Sitter/Feeder Seat<br>HB Hospital Beds<br>HEA Hearing Aids<br>HH Home Health<br>HSPC Hospice<br>IPT Infusion/Parental Therapy<br>ITA Inpatient admission - ITA<br>JRA JRA<br>LTAC LTAC<br>MC Medication<br>MISC Miscellaneous<br>MN Medical Nutrition<br>MWH Manual Wheelchair - Home<br>MWNF Manual Wheelchair - NF<br>O Other<br>ODC Orthodontic<br>ODME Other DME<br>OOS Out of State<br>OP Ostomy Products<br>OS Orthopedic Shoes<br>OTC Orthotics<br>PAS PAS<br>PDN Private Duty Nursing<br>PHY Pharmacy<br>PL Patient Lifts<br>PMR PM and R<br>PROS Prosthetics<br>PRS Prone Standers<br>PSY Psychotherapy<br>PTL Partial<br>PWH Power Wheelchair - Home<br>PWNF Power Wheelchair – NF<br>PWNF Power Wheelchair - NF<br>PHYS Physician Services<br>R Respiratory<br>RBS Rebases<br>RE Room equipment<br>RLNS Relines<br>RM Readmission<br>S Surgery<br>SBS Specialty Beds/Surfaces<br>SC Shower chairs<br>SCAN MRI/PET Scans<br>SF Standing Frames<br>SGD Speech Generating Device<br>SSIP Short Stay (In-Patient)<br>T Therapies (PT/OT/ST)<br>TRN Transportation<br>TU TENS Units<br>US Urinary Supplies<br>V Vision<br>VNSS Vagus nerve stimulator surgery<br>VOL Inpatient admission-Voluntary<br>WDCS Wound/decubiti care supplies |

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|---|---|---|
| 3. | Name: Required. | Enter the last name, first name, and middle initial of the patient you are requesting authorization for. |
| 4 | Client ID: Required. | Enter the client ID = 9 numbers followed by WA.<br>For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending):<br>▪ You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions).<br>▪ A reference PA will be built with a placeholder client ID.<br>▪ If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID.<br>▪ The PA will be updated and you will be able to bill the services approved. |
| 5 | Living Arrangements | Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. |
| 6 | Reference Auth # | If requesting a change or extension to an existing authorization, please indicate the number in this field. |
| 7 | Requesting NPI #: Required. | The 10 digit numeric number that has been assigned to the requesting provider by CMS. |
| 8 | Requesting Fax# | The fax number of the requesting provider. |
| 9 | Servicing NPI #: Required. | The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS. |
| 10 | Name | The name of the billing/servicing provider. |
| 11 | Referring NPI # | The 10 digit numeric number that has been assigned to the referring provider by CMS. |
| 12 | Referring Fax # | The fax number of the referring provider. |
| 13 | Service Start Date | The date the service is planned to be started if known. |
| 15 | Description of service being requested: Required. | A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid). |
| 18 | Serial/NEA#: Required for all DME repairs. | Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request. |
| 20 | Code Qualifier: Required. | Enter the letter corresponding to the code from below:<br>T - CDT Proc Code<br>C - CPT Proc Code<br>D - DRG<br>P - HCPCS Proc Code<br>I - ICD-9/10 Proc Code<br>R - Rev Code<br>N - NDC-National Drug Code<br>S - ICD-9/10 Diagnosis Code |
| 21 | National Code: Required. | Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered. |
| 22 | Modifier | When appropriate enter a modifier. |
| 23 | # Units/Days Requested: Required. | Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific Billing Instructions for the appropriate unit/day designation for the service code entered). |
| 24 | $ Amount Requested: Required. | Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g. $400 should be entered as 400.00. |
| 25 | Part # (DME only): Required for all "By Report" codes requested. | Enter the manufacturer part # of the item requested. |

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| 26 | Tooth or Quad#: Required for dental requests | Enter the tooth or quad number as listed below:<br>QUAD<br>00 – full mouth<br>01 – upper arch<br>02 – lower arch<br>10 – upper right quadrant<br>20 – upper left quadrant<br>30 – lower left quadrant<br>40 – lower right quadrant<br>Tooth # 1-36, A-T, AS-TS, 51-82 and SN |
| 27 | Diagnosis Code | Enter appropriate diagnosis code for condition. |
| 28 | Diagnosis name | Short description of the diagnosis. |
| 29 | Place of Service | Enter the appropriate two digit place of service code. |
| 30 | Comments | Enter any free form information you deem necessary. |

| Field | Name | Action |
|---|---|---|
| | | ALL FIELDS MUST BE TYPED |
| 1 | **Org required** | Enter the Number that Matches the Program/Unit for the Request<br><br>~~500 - Division of Alcohol and Substance Abuse (DASA)~~<br>~~501 - Dental~~<br>~~502 - Durable Medical Equipment (DME)~~<br>~~509 - Economic Services Administration (ESA)~~ ~~(DSHS)~~<br>~~504 - Home Health~~<br>~~505 - Hospice~~<br>~~506 - Inpatient Hospital~~<br>~~507 - Juvenile Rehabilitation Administration (JRA)~~ ~~(DSHS)~~<br>**508 - Medical**<br>~~509 - Medical Nutrition~~<br>~~510 - Mental Health~~<br>~~511 - Outpt Proc/Diag~~<br>~~513 - Physical Medicine & Rehabilitation (PM & R)~~<br>~~514 - Aging and Disability Services Administration (ADSA)~~<br>~~515 - Transportation~~<br>~~516 - Miscellaneous~~ |
| 2 | **Service Type required** | Enter the letter(s) in all CAPS that represent the service type you are requesting.<br><br>~~AA~~ ~~Ambulatory Aids~~<br>~~BB~~ ~~Bath Bench~~<br>~~BEM~~ ~~Bath Equipment (misc)~~<br>~~BGM~~ ~~Blood Glucose Monitors~~<br>~~BGS~~ ~~Bone Growth Stimulator~~<br>~~BP~~ ~~Breast Pumps~~<br>~~BS~~ ~~Bariatric surgery~~<br>~~BSS2~~ ~~Bariatric surgery stage 2~~<br>~~C~~ ~~Commode~~<br>~~CI~~ ~~Cochlear Implants~~<br>~~CIERP~~ ~~Cochlear Implant Ext Repl Prts~~<br>~~CSC~~ ~~Commode/Shower Chair~~<br>~~CWN~~ ~~Crowns~~<br>~~DASA~~ ~~DASA~~<br>~~DEN~~ ~~Dentures~~<br>~~EN~~ ~~Enteral Nutrition~~<br>~~ESA~~ ~~ESA~~<br>~~FSFS~~ ~~Floor Sitter/Feeder Seat~~<br>~~HB~~ ~~Hospital Beds~~<br>~~HEA~~ ~~Hearing Aids~~<br>~~HH~~ ~~Home Health~~<br>~~HSPC~~ ~~Hospice~~<br>~~IPT~~ ~~Infusion/Parental Therapy~~<br>~~ITA~~ ~~Inpatient admission - ITA~~<br>~~JRA~~ ~~JRA~~<br>~~LTAC~~ ~~LTAC~~ |

| Field | Name | Action |
|---|---|---|
| | | ~~MC~~ ~~Medication~~<br>~~MISC~~ ~~Miscellaneous~~<br>~~MN~~ ~~Medical Nutrition~~<br>~~MWH~~ ~~Manual Wheelchair - Home~~<br>~~MWNF~~ ~~Manual Wheelchair - NF~~<br>~~O~~ ~~Other~~<br>~~ODC~~ ~~Orthodontic~~<br>~~ODME~~ ~~Other DME~~<br>~~OOS~~ ~~Out of State~~<br>~~OP~~ ~~Ostomy Products~~<br>~~OS~~ ~~Orthopedic Shoes~~<br>~~OTC~~ ~~Orthotics~~<br>~~PAS~~ ~~PAS~~<br>~~PDN~~ ~~Private Duty Nursing~~<br>~~PHY~~ ~~Pharmacy~~<br>~~PL~~ ~~Patient Lifts~~<br>~~PMR~~ ~~PM and R~~<br>~~PROS~~ ~~Prosthetics~~<br>~~PRS~~ ~~Prone Standers~~<br>~~PSY~~ ~~Psychotherapy~~<br>~~PTL~~ ~~Partial~~<br>~~PWH~~ ~~Power Wheelchair - Home~~<br>~~PWNF~~ ~~Power Wheelchair - NF~~ |
| | | ~~PWNF~~ ~~Power Wheelchair - NF~~<br>~~PHYS~~ ~~Physician Services~~<br>~~R~~ ~~Respiratory~~<br>~~RBS~~ ~~Rebases~~<br>~~RE~~ ~~Room equipment~~<br>~~RLNS~~ ~~Relines~~<br>~~RM~~ ~~Readmission~~<br>~~S~~ ~~Surgery~~<br>~~SBS~~ ~~Specialty Beds/Surfaces~~<br>~~SC~~ ~~Shower chairs~~<br>~~SCAN~~ ~~MRI/PET Scans~~<br>~~SF~~ ~~Standing Frames~~<br>~~SGD~~ ~~Speech Generating Device~~<br>~~SSIP~~ ~~Short Stay (In-Patient)~~<br>**T** **Therapies (PT/OT/ST)**<br>~~TRN~~ ~~Transportation~~<br>~~TU~~ ~~TENS Units~~<br>~~US~~ ~~Urinary Supplies~~<br>~~V~~ ~~Vision~~<br>~~VNSS~~ ~~Vagus nerve stimulator surgery~~<br>~~VOL~~ ~~Inpatient admission-Voluntary~~<br>~~WDCS~~ ~~Wound/decubiti care supplies~~ |
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| 5 | **Living Arrangements** | ~~Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.~~ NOT REQUIRED FOR THERAPIES |
| 6 | **Reference Auth #:** | If requesting a change or extension to an existing authorization, please indicate the number in this field. |
| 7 | **Requesting NPI #: Required.** | The 10 digit numeric number that has been assigned to the requesting provider by CMS. |
| 8 | **Requesting Fax#:** | The fax number of the requesting provider. |
| 9 | **Servicing NPI #: Required.** | The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS. |
| 10 | **Name:** | The name of the billing/servicing provider. |
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| 24 | **$ Amount Requested: Required.** | NOT REQUIRED FOR THERAPIES ~~Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a decimal (e.g.~~ |

| Field | Name | Action |
|---|---|---|
| | | ~~$400 should be entered as 400.00.~~ |
| 25 | **Part # (DME only): Required for all "By Report" codes requested.** | NOT REQUIRED FOR HEARING AIDS ~~Enter the manufacturer part # of the item requested.~~ |
| 26 | **Tooth or Quad#: Required for dental requests** | NOT REQUIRED FOR HEARING AIDS<br>~~Enter the tooth or quad number as listed below:~~<br>~~QUAD~~<br>~~00 – full mouth~~<br>~~01 – upper arch~~<br>~~02 – lower arch~~<br>~~10 – upper right quadrant~~<br>~~20 – upper left quadrant~~<br>~~30 – lower left quadrant~~<br>~~40 – lower right quadrant~~<br><br>~~Tooth # 1-36, A-T, AS-TS, 51-82 and SN~~ |
| 27 | **Diagnosis Code:** | Enter appropriate diagnosis code for condition. |
| 28 | **Diagnosis name** | Short description of the diagnosis. |
| 29 | **Place of Service** | Enter the appropriate two digit place of service code.<br>**Use 11 for office or 22 for outpatient hospital.** |
| 30 | **Comments:** | Enter any free form information you deem necessary. |